

REQUEST FOR INDEPENDENT MEDICAL EXAMINATION
MAINE WORKERS' COMPENSATION BOARD
OFFICE OF MEDICAL/REHABILITATION SERVICES
27 STATE HOUSE STATION
AUGUSTA, ME 04333-0027
(207) 287-7062

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER (last 4 digits): XXX-XX-	7. DATE OF BIRTH:		
2. EMPLOYER NAME:	8. EMPLOYEE LAST NAME:	9. FIRST NAME:	10. M.I.:	
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. EMPLOYEE ADDRESS-NUMBER AND STREET:			
4. INSURER NAME:	12. CITY:	13. STATE:	14. ZIP:	15. HOME PHONE:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:		17. WCB FILE NUMBER:	
18. ADJUSTER NAME, PHONE AND EMAIL ADDRESS:				

<p>NATURE OF INJURY: _____</p> <p>AGREED UPON INDEPENDENT MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>IF YES, NAME, ADDRESS AND TELEPHONE: OF AGREED UPON EXAMINER: _____</p> <p>IF NO, HAS THERE BEEN AN UNSUCCESSFUL MEDIATION OR HAS A REQUEST FOR PROVISIONAL ORDER BEEN ACTED ON AND THE CASE IS PROCEEDING TO THE FORMAL HEARING LEVEL? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>IF YES, PETITIONS PENDING: _____</p> <p>HEARING OFFICER: _____</p> <p>PREFERRED SPECIALTY, IF ANY (NOTE:THE BOARD IS NOT BOUND BY SUCH PREFERENCE): _____</p>

<p>QUESTIONS RELATING TO THE MEDICAL CONDITION OF THE EMPLOYEE (ATTACH A SEPARATE SHEET OF PAPER IF NECESSARY):</p>

<p>LIST ALL INTERESTED PARTIES AND WHOM EACH REPRESENTS (EE OR ER) (ATTACH A SEPARATE SHEET OF PAPER IF NECESSARY). NOTE: COPIES OF THIS DOCUMENT MUST BE MAILED OR DELIVERED TO ALL PARTIES LISTED HERE.</p>				
ER/EE: _____	NAME: _____	CLIENT: _____	ADDRESS: _____	PHONE: _____
ER/EE: _____	NAME: _____	CLIENT: _____	ADDRESS: _____	PHONE: _____
ER/EE: _____	NAME: _____	CLIENT: _____	ADDRESS: _____	PHONE: _____
ER/EE: _____	NAME: _____	CLIENT: _____	ADDRESS: _____	PHONE: _____
ER/EE: _____	NAME: _____	CLIENT: _____	ADDRESS: _____	PHONE: _____

REQUESTER NAME, ADDRESS, TELEPHONE NUMBER AND EMAIL ADDRESS:	DATE MAILED:
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